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Nurturing the Scientific Enterprise—James B. Wyngaarden 155

The Challenge of Governance: The Relationship of the Teaching Hospital to the University—Robert M. Heyssel 162

Perceived Stress in Medical, Law, and Graduate Students—Marilyn Heins, Shirley Nickols Fahey, and Lisa I. Leiden 169

Response of Faculty Members to Medical Students' Personal Problems—James C. Brown and John M. Barnett 180

Tutored Videotape-Instruction in Clinical Decision-Making—Harold C. Sox, Jr., Keith I. Marton, Michael C. Higgins, and David H. Hickam 188

Communications: Use of Anonymous Student Evaluations of Faculty Members in U.S. Medical Schools—Stephen R. Smith and Leslie J. Paulen 196

A Study of Newly Licensed Physicians—Jenifer Ehreth 198

Advanced Cardiac Life-Support Training for Medical Students and House Officers—Judith Tintinalli, Scott Freeman, Susan Kalia, and Barbara Laubscher 200

Increasing Medical Students' Awareness of Psychological Concomitants of Illness—John Misiaszek 203

A Stress Discussion Group for Medical Interns—John L. Ziegler, Nick Kanas, William M. Strull, and Nancy E. Bennet 205

Editorials: Trust and Understanding Between Heads of Medical School and Teaching Hospital: Requisite for Good Management 208

Balancing Independence and Interdependence: Key to Preserving Medical School–Teaching Hospital Tandem 209

Bibliography 211

Letter to the Editor 215

Supplement: AAMC Annual Meeting and Annual Report, 1983 217

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Response of Faculty Members To Medical Students' Personal Problems

James C. Brown, Ph.D., and John M. Barnett, Ph.D.

Abstract—In the study reported here, the authors examined the interpersonal helping behaviors of medical educators. Ninety-six faculty members from 12 randomly selected medical schools completed a detailed questionnaire providing data on the nature and frequency of their interpersonal behaviors with students experiencing personal problems. The faculty members reported spending an average of 48.6 minutes a week discussing personal problems with students. Student problems reported most frequently pertained to financial concerns, emotional health, and interactions with faculty members. Medical educators used various techniques to offer help; the most commonly reported techniques were listening, asking questions to draw the student out, offering support and sympathy, and offering empathy. Most medical faculty members felt positive about their role as "helper" and rated that component of their job as extremely important. The implications of these findings, especially for staffing and personnel policy, are discussed.

The stress of health care education, especially medical school training, has been noted in the literature as a serious issue for students in these fields (1–4). In the medical school setting, for example, a number of factors have been identified as stressors, including didactic and clinical examinations, the amount of information to be learned, the number of hours of work required, the students' preoccupation with success and the consequent fear of failure, and the limited support and positive feedback provided by the faculty (5, 6).

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The potential negative impact of such stressors on medical students is a serious matter and one worthy of concern on the part of all those involved in medical education (7, 8). One important aspect of this matter is the support or help available to medical students as they encounter various stressors and attempt to deal with the resultant distress in their personal and professional lives. The potential interpersonal support available from faculty members would seem to be particularly significant. This is true especially in light of student access to faculty members, the degree of interaction between faculty members and students, and the relatively limited availability of formal mental health services. In fact, it is now well documented that individuals are more likely to seek help for personal problems

from "informal helpers" than from mental health professionals (9, 10).

Consequently, based on the extent of interaction between medical faculty members and students and their common perspective, it would seem likely that the help of faculty members would be requested by students in need, especially if the former are trusted and liked. It has even been suggested by Aspy (11) that such interpersonal helping skills are an important determiner of effective teaching. He writes that "learning is a process which . . . can be enhanced or diminished in effectiveness according to the degree of interpersonal facilitation with which it is carried out."

While there is limited information suggesting that educators in general are called on to help with students' personal problems (12), there appear to be no systematic data as to specific helping behaviors of faculty members in the health care professions. Because of the documented stress factors which are a part of professional health education, it is useful to assess the interpersonal helping behaviors and attitudes of the faculties in such settings. Therefore, the study reported here was designed to determine the extent of involvement by medical faculty members in students' personal problems, the kind of problems involved, specific helping techniques used by faculty members, and the faculty members' attitudes concerning their role as "helper." The present study is one in a series of such efforts to document the nature of interpersonal helping behaviors by medical, dental, and nursing educators.

Method

All data were obtained from a faculty-student interaction inventory developed by the authors and adapted from an earlier inventory reported by Cowen (13). The revised inventory, a 14-item questionnaire,* several items of which had multiple parts, was designed to secure information in the following areas:

1. Time spent per week by faculty members discussing students' personal problems (defined on the questionnaire as "problems that cause moderate to serious concerns or upsets and which can be school or non-school related").

2. The nature of student problems discussed. Faculty respondents were asked to report on a 4-point scale (0 = very infrequent, 3 = very frequent) the frequency with which they encounter 17 problem areas (such as alcohol and drug abuse, financial problems, emotional health concerns, patient-student difficulties, and didactic and clinical academic problems) and to rank-order the three problems with which they had the most difficulty in offering help.

3. Problem-handling strategies. Faculty members rated 15 helping strategies (for example, "give advice," "listen," "suggest alternatives," "refer to someone else") as to how frequently they were employed on the same 4-point frequency scale described above.

4. Feelings experienced by faculty members as a function of their dealing with students' problems. Using the 4-point frequency scale, respondents rated 12 emotional reactions (for example, helpless, pleased, angry, uncomfortable) that they experienced when called on to handle student problems.

5. Perceived importance of dealing with students' problems and self-assessment of helping effectiveness. On a 5-point frequency scale, faculty members rated how important they felt it was to both listen and respond to students' personal problems; on an 8-point scale (1 = extremely ineffective, 8 = extremely ef-

* Copies of the questionnaire are available from the authors.

fective), faculty members also rated their own effectiveness in dealing with student problems.

6. Background data, including the faculty member's sex, age, highest degree, years of faculty experience, a brief description of academic responsibilities, and the number and class/level of students taught.

Subjects for the present study were 96 full-time faculty members in U.S. schools of medicine; the sample included 86 males and 10 females. The mean age of the group was 44.9 years; the average length of academic experience was 12.16 years. Of the sample, 77.6 percent held M.D. degrees, 13.8 percent held Ph.D. degrees in their fields, 3.4 percent held master's degrees, and 5.2 percent held both the M.D. and Ph.D. degrees. The sample was representative of all clinical and basic science departments.

The faculty sample consisted of those responding to the faculty-student intervention inventories, which were mailed to faculty members of 12 schools of medicine randomly selected from among all U.S. medical schools. The 12 schools selected are geographically representative of the country. Four are in the Southeast, and two each are in the West, Midwest, Southwest, and Northeast. The questionnaires were sent to a 10 percent sample randomly selected from complete faculty listings in each school's academic bulletin. The inventory, along with a covering letter providing the rationale for the study, was mailed individually to each selected faculty member. The number of returned inventories from the 12 schools ranged from 4 to 16 for a total return rate of 41 percent. Five of the returned questionnaires had to be discarded because of insufficient data; the remainder were complete and appeared to have been carefully done.

Results

On the average, members of the medical faculty sample spent .81 hours, or 48.6 minutes, per week discussing personal problems with .93 students. It was reported that approximately 78 percent of those discussions were initiated by the students, 15 percent by the faculty members themselves, and 7 percent by a third party. Seventy-four percent of the personal problem discussions took place during regular school hours, 15 percent during lunch or break time, 9 percent after regular school hours, including weekends, and 2 percent during nondesignated "other" times. As to the location of the discussions, 76 percent took place in an office or other private area, 9 percent in a classroom or clinic, 6 percent in a location such as a restaurant or snack bar, 7 percent in a hallway or a similar area, and 2 percent in nondesignated "other" locations.

Data are presented in Table 1, on the means, standard deviations, and rank order for frequency of the discussions and the extent of the difficulty in providing help for specific problems. The most commonly occurring problems were career reconsideration, faculty-student interactions, school-related clinical issues, and school-related didactic concerns. The medical educators reported the problems with which they had the most difficulty helping students to be financial concerns, emotional health issues, and faculty-student problems.

A Pearson product-moment correlation was used to assess the relationship between the mean frequency of occurrence of problems and the perceived difficulty in helping with those problems. The resulting correlation of .75 indicated a relative dependence of ranking for difficulty and frequency by respondents;

TABLE 1

Frequency of Occurrence Means, Standard Deviations, and Rank Orders of Student Problems and Perceived Problem Difficulty Reported by National Sample of 96 U.S. Medical School Faculty Members, 1983

Student Problem	Means Frequency*	S.D.	Rank Order Frequency	Rank Order Difficulty†
Career consideration	1.38	1.14	1	7.5
Faculty-student	1.11	1.05	2	3
School related—clinical	1.02	1.03	3	6
School related—didactic	1.00	.96	4	9.5
Marriage	.86	1.00	5	4
Financial	.78	.95	6	1
Peer interaction	.72	.96	7	5
Emotional health	.69	.88	8	2
Patient-student	.63	.89	9	13
Physical health	.47	.65	10	14
School administration	.47	.68	11	7.5
Dating relationships	.35	.64	12	9.5
Sex	.31	.62	13	12
Parent-student	.28	.61	14	18
Drug abuse	.16	.52	15	11
Other‡	.16	.58	16	17
Child care	.12	.33	17	16
Alcohol abuse	.07	.25	18	15

* Based on 4-point scale (0 = very infrequent; 1 = infrequent; 2 = frequent; 3 = very frequent).

† Difficulty based on respondents ranking the three most difficult problems with which they had to deal.

‡ Examples are: choice of specialty, religious concerns, time management.

that is, respondents had more difficulty dealing with problems that occurred most frequently.

Helping strategies used by medical faculty members and the means, standard deviations, and rank order for their frequency are listed in Table 2. As can be noted, the most frequently employed helping techniques were to listen, to ask questions to draw the student out, to offer support and sympathy, and to offer empathy. Sixty percent of the sample reported that they frequently referred students with personal problems to others for help, and approximately 24 percent of the sample reported the strategy of "try to avoid getting involved" as a way of dealing with student problems.

Frequency data in the form of means, standard deviations, and rank order of the feelings faculty members experienced when asked to deal with student problems are given in Table 3. The most frequent feelings reported were those of sympathy, support, pleasure, and encouragement, while negative emotional responses to helping were reported relatively infrequently.

On a 1-through-5 scale (1 = extremely unimportant; 5 = extremely important), the mean rating of perceived importance of listening to students' personal problems was 4.35. The respondents' mean rating concerning their perceived importance of responding to students' personal problems was 4.23. Finally, on an 8-point scale of rating their own effectiveness in dealing with student problems (1 = extremely ineffective; 8 = extremely effective), members of the medical faculty

TABLE 2

Frequency of Occurrence Means, Standard Deviations, and Rank Order of Behaviors Used To Help Students by National Sample of 96 U.S. Medical School Faculty Members, 1983

Behavior	Means Frequency*	S.D.	Rank Order
Listen	1.95	1.18	1
Ask questions to draw student out	1.57	1.18	2
Offer support and sympathy	1.55	1.16	3
Put self in student's place and be empathetic	1.43	1.10	4
Get student to come up with alternatives	1.36	1.05	5
Suggest alternatives	1.34	1.01	6
Give advice	1.30	1.10	7
Share personal experiences	1.15	1.03	8
Refer the student to someone else	.93	.89	9
Actively intercede on behalf of student	.80	.89	10
Tell student cannot help	.56	.68	11
Try to be lighthearted	.47	.75	12
Tell student to count blessings	.33	.66	13
Try to avoid getting involved	.24	.43	14
Change the topic	.07	.25	15.5
Other	.07	.36	15.5

* Based on 4-point scale (0 = very infrequent; 1 = infrequent; 2 = frequent; 3 = very frequent).

sample saw themselves as moderately effective helpers (mean = 1.98).

Discussion

Despite the inherent problems of surveys and self-report research of the type reported here, the present study does provide preliminary data concerning a significant facet of medical education—the issue of faculty response to potentially stressful personal problems experienced by students.

The personal aspect of the medical student's life increasingly is being documented as a significant factor in professional training. However, the reported figure of only 48.6 minutes spent with approximately one student per week dealing with personal concerns and issues would seem to belie such importance. Particularly when compared with the reported 2.5 hours a week spent by industrial foremen in dealing with similar concerns on the part of their workers (14), this figure appears limited. On the other hand, however, it could be argued that in the hectic, never-enough-time world of medical school, the major focus of medical education is, and should be, one of providing clinical and academic experiences for the student. In such settings, little time or encouragement is typically available for the kind of personal helping interactions at issue here.

Faculty respondents in the present study reported that the problems they encountered most often were school-related in nature, that is, career reconsideration, faculty-student concerns, and school-related clinical and didactic issues. Certainly, the nature of the academic environment in which faculty members and students interact would predict such an emphasis. The next most commonly reported problems by faculty members in-

TABLE 3

Frequency of Occurrence Means, Standard Deviations, and Rank Order of Feelings in Response to Helping with Students' Personal Problems by National Sample of 96 U.S. Medical School Faculty Members, 1983

Feelings	Means Frequency*	S.D.	Rank Order
Sympathetic	1.76	1.04	1
Supportive	1.74	1.09	2
Pleased	1.34	.93	3
Encouraged	1.25	.99	4
Frustrated	.63	.75	5
Helpless	.59	.81	6
Puzzled	.58	.66	7
Uncomfortable	.53	.68	8
Depressed	.29	.53	9
Angry	.28	.52	10.5
Trapped	.28	.50	10.5
Bored	.22	.46	12

* Based on 4-point scale (0 = very infrequent; 1 = infrequent; 2 = frequent; 3 = very frequent).

cluded a grouping of problems not school-related or possibly only indirectly related—those dealing with marriage, financial concerns, peer interaction issues, and emotional health. Each of these four problem areas also was listed as among the more difficult with which the faculty members had to deal; this possibly reflected a lack of specific training and limited confidence in responding to such sensitive nonschool issues.

Among the various helping behaviors used by faculty members to respond to student problems, the most common was simply to listen. After listening, such helping strategies as asking questions and offering support and sympathy were reported with almost an equal frequency, followed by a close grouping of four other helping techniques—being empathetic, getting the student to generate alternatives, suggesting alternatives, and giving advice. Of these seven most frequently employed strategies, four of them are basically nondirective in nature (listening, offering support and sympathy, being empathetic, and getting the student to come up with alternatives), while the remaining three techniques are directive or action-oriented approaches (asking questions, suggesting alternatives, and giving advice).

The cluster of most frequently reported feelings by faculty members in response to providing help—sympathetic, supportive, pleased, and encouraged—indicates an overall positive response to being cast in the role of interpersonal helper. Although not as frequent, negative feelings such as frustration, helplessness, and puzzlement also were reported as responses to this question; this possibly reflected the lack of specific training in interpersonal helping skill areas as well as the common frustration experienced by even professional mental health workers.

The medical educators as a group felt strongly that it was important both to listen and respond to students' personal problems. Even so, the respondents only saw themselves as moderately effective (4.98 on an 8-point scale) in providing those listening and responding skills. Again, this may reflect limited training on the part of faculty members in interpersonal helping skills and thus a lack of confidence in their abilities in this endeavor. A limitation of the present study in this regard is a lack of data concerning the actual effectiveness of faculty members in helping with student problems and the effectiveness as perceived by students themselves. In addition, information is not available concerning the relative effectiveness of the various helping strategies used by faculty members. These are areas that should be explored.

As noted above, the major purpose of the study reported here was to gather data concerning the helping behavior of medical educators in dealing with their students' personal problems. Potentially important information has been elicited regarding the kinds of problems faced by

medical faculties, the strategies employed by faculty members in response to these problems, the emotional impact on the faculty members as a function of their placing themselves in the role of helper, and perceptions of the importance and effectiveness of their efforts. The data are, of course, open to various judgments and interpretations, some of which are offered here. Individual schools of medicine and individual faculty members obviously can judge the applicability and heuristic value of these data for their own settings.

Finally, it should be pointed out that medical educators as well as educators in the other health professions must be aware of and respond to their students' personal or psychological concerns for functional reasons if for no other. That is, it is now well established that personal stressors can have a significant impact on the motivation and academic performance of students. Therefore, the degree to which faculty members can respond effectively to students' personal problems rather than ignore them is the degree to which the overall educational task will be made easier. Realistically, it is the faculty member who is likely to notice students who may be having personal problems, or at least their effect, and consequently be in the best position to respond to them in some fashion. It is not being suggested that medical educators all become psychotherapists. What is being suggested, however, is that the effectiveness of the professional medical educator can be improved by additional training in interpersonal skills designed to improve listening, communication, and problem-solving abilities. The need for such skills is supported by the finding of the present study that while respondents judged listening and responding to student problems as important, they saw their own skills in delivering such help as only moderately effective. The occasional continuing education offerings in this area could be expanded to meet such a training need. Or, just as important, more awareness of the value of interpersonal skills may be called for in the selection and promotion of medical faculty members. Such an emphasis and expanded role can aid in producing more professionally and personally productive medical graduates as well as more effective and satisfied medical educators, educators who will be able and inclined to do more than "try not to get involved" in students' personal problems.

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COMMUNICATIONS

Use of Anonymous Student Evaluations Of Faculty Members in U.S. Medical Schools

Stephen R. Smith, M.D., and Leslie J. Paulen

After nearly three decades of debate and numerous articles on the subject, most authorities agree that student evaluations of faculty members have both value and validity. They agree that student evaluations are able to discriminate consistently the good and bad teacher and to correlate well with other measures of teacher effectiveness, including the evaluations of other faculty members.

As the debate over whether or not to have students evaluate faculty members has subsided, a new contentious issue has arisen: Should students be allowed to retain anonymity when they evaluate faculty members?

A small number of research studies have been published relating to the issue of anonymity. Among those studies that were conducted in real classroom situations and that used control groups, all but one show a statistically significant effect of anonymity on ratings by students, indicating that faculty members were rated more favorably on positive items and less unfavorably on negative items when ratings were signed than when they were unsigned (1–4). The one study that did not demonstrate that effect was by Stone and colleagues (5).

The present study was undertaken to ascertain the degree to which the anonymity of student evaluations of faculty members takes place at U.S. medical schools. A corollary interest was to discover the extent to which student evaluations of faculty are used in deciding on faculty promotion, tenure, and salaries.

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Methods

A telephone survey was conducted by the authors in June, July, and August 1983 of 126 U.S. medical schools. The Association of American Medical Colleges' *1982–83 Curriculum Directory* was used to obtain the name of the medical school, the contact person at the school, and the telephone number. At least three attempts were made to contact someone at the school who could answer the four-question survey.

Results

Of the 126 medical schools, responses were obtained from 120 (95 percent). Of the nonresponding schools, two refused to provide answers to questions posed over the telephone. The lack of a response from the rest was due to the inability of the authors to reach someone who could answer the questions despite repeated attempts. The results of the survey are shown in Table 1.

Only two schools reported that they required students to identify themselves on the evaluation form and did not guarantee anonymity. In one of them, the student's school identification number was required; in the other, the student's name was required. Eighty-three schools did not require the students to identify themselves. Nine schools classified as giving other responses all involved explanations of how anonymity was guaranteed, although students were required to put some form of identification on the evaluation sheet. This frequently involved putting students' names on front sheets that were discarded prior to being sent to the faculty members. In only one of the schools whose responses were recorded under other was the

TABLE 1

Results of 1983 Telephone Survey of 120 U.S. Medical Schools on Use of Anonymous Student Evaluations of Teaching Faculty

Type of Evaluation	Yes Response		No Response		Other Response	
	No.	Percent	No.	Percent	No.	Percent
Students regularly evaluate faculty	93	77.5	23	19.2	4	3.3
Evaluation is written	94	98.9	1	1.1	0	0.0
Students must identify themselves	2	2.1	83	88.3	9	9.6
Evaluations used in promotion, tenure, or salary decisions	35	36.8	43	45.3	17	17.9

identity of students made available to faculty members and then only with clinical courses; anonymity was guaranteed in basic science courses in that school.

Discussion

The results of the study reported here indicate that most U.S. medical schools now have a formal system in which students evaluate the teaching faculties. Nearly all of these schools use a system to ensure student anonymity. The preponderance of data gathered by other investigators (1–4) indicates that ratings would be higher if anonymity were not guaranteed. Because of the lack of significant difference in the one study (5), Stone and colleagues suggest that ratings be signed by students. Those authors offer as justification for this suggestion the potential for better data analysis, the ability to reach the student for clarification, and a decrease in the number of random responses by students. However, these benefits are theoretical and have not been empirically tested. An opposite argument could be made that even if there were negligible amounts of response bias between signed and unsigned ratings, unsigned ratings would be preferable because response rates might be higher, students might feel freer in writing insightful comments, and they might interpret the anonymity provision as a sign of trust in their ability to act responsibly.

These conflicting arguments could and should be subjected to experimental testing. Meanwhile, the current widespread practice of using anonymous ratings by students should be continued.

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